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October 14, 2003
DEPARTMENT OF ENERGY
OFFICE OF HEARINGS AND APPEALS

Hearing Officer's Decision

Name of Case: **Personnel Security Hearing**

Date of Filing: **March 20, 2003**

Case Number: **TSO-0027**

This Decision considers the eligibility of XXXXXXXX XXXXXXXX (hereinafter referred to as "the individual") to hold an access authorization under the regulations set forth at 10 C.F.R. Part 710, entitled "Criteria and Procedures for Determining Eligibility for Access to Classified Matter or Special Nuclear Material." As explained below, it is my decision that the individual's access authorization should not be restored.

I. *BACKGROUND*

The individual is an employee of a Department of Energy (DOE) contractor. The individual possessed a DOE access authorization for several years, but this clearance was suspended in 2002 pending the resolution of questions regarding the individual's eligibility for access authorization. DOE security personnel had conducted an interview with the individual in March 2002 (the 2002 PSI). In addition, at the request of DOE security, the individual was evaluated in July 2002 by a DOE-consultant psychiatrist (hereafter "the DOE psychiatrist"), who issued a Report containing his findings and recommendations on July 13, 2002 (the "Report"). In October 2002, the Director of Personnel Security of the Area Office (the Security Director) issued a Notification Letter to the individual. In this letter, the Security Director states that the individual has raised security concerns under Sections 710.8(j) and (l) of the regulations governing eligibility for access to classified material. Specifically, with respect to Criterion (j), the Security Director finds that the individual has been diagnosed by the DOE psychiatrist as suffering from Alcohol Abuse, and that this psychiatrist also has concluded that, as of July 2002 there

was not adequate evidence of rehabilitation or reformation from this condition.

With respect to Criterion (l), the Security Director finds that information in the possession of the DOE indicates that the individual has engaged in unusual conduct or is subject to circumstances which tend to show that he is not honest, reliable, or trustworthy, or which furnishes reason to believe that he may be subject to pressure, coercion, exploitation or duress. Specifically, the Operations Office refers to the individual's alcohol related arrests in February 2002 and in December 1988, his being charged with "Drunk on Duty" in December 1985 while serving in the Navy, and his admission that in the past 14 years he has driven while legally intoxicated.

The individual requested a hearing to respond to the concerns raised in the Notification Letter. In his response to the Notification Letter, the individual challenged the DOE psychiatrist's conclusion that he suffered from alcohol abuse. He also stated that he had entered into a recovery program through his employer's Employee Assistance Program (EAP). The Hearing was convened in late July 2003, and focused chiefly on the merits and accuracy of the DOE psychiatrist's report and his conclusion. Testimony was received from only three persons. The DOE presented the testimony of a personnel security specialist and the DOE psychiatrist. Although I repeatedly advised the individual of his need to provide corroborative testimony from expert medical witnesses and individuals who were knowledgeable concerning the individual's current efforts to maintain his sobriety, he testified on his own behalf and presented no other witnesses.

II. *REGULATORY STANDARD*

In order to frame my analysis, I believe that it will be useful to discuss briefly the respective requirements imposed by 10 C.F.R. Part 710 upon the individual and the Hearing Officer. As discussed below, Part 710 clearly places upon the individual the responsibility to bring forth persuasive evidence concerning his eligibility for access authorization, and requires the Hearing Officer to base all findings relevant to this eligibility upon a convincing level of evidence. 10 C.F.R. §§ 710.21(b)(6) and 710.27(b), (c) and (d).

A. *The Individual's Burden of Proof*

It is important to bear in mind that a DOE administrative review proceeding under this Part is not a criminal matter, where the government would have the burden of proving the defendant guilty beyond a reasonable doubt. The standard in this proceeding places the burden of proof on the individual. It is designed to protect national security interests. The hearing is "for the purpose of affording the individual an opportunity of supporting his eligibility for access authorization." 10 C.F.R. § 710.21(b)(6). The individual must come forward at the hearing with evidence to convince the DOE that restoring his access authorization "would not endanger the common defense and security and would be clearly consistent with the national interest." 10 C.F.R. § 710.27(d). *Personnel Security Review (Case No. VSA-0087)*, 26 DOE ¶ 83,001 (1996); *Personnel Security Hearing (Case No. VSO-0061)*, 25 DOE ¶ 82,791 (1996), *aff'd*, *Personnel Security Review (VSA-0061)*, 25 DOE ¶ 83,015 (1996). The individual therefore is afforded a full opportunity to present evidence supporting his eligibility for an access authorization. The regulations at Part 710 are drafted so as to permit the introduction of a very broad range of evidence at personnel security hearings. Even appropriate hearsay evidence may be admitted. 10 C.F.R. § 710.26(h). Thus, by regulation and through our own case law, an individual is afforded the utmost latitude in the presentation of evidence which could mitigate security concerns.

Nevertheless, the evidentiary burden for the individual is not an easy one to sustain. The regulatory standard implies that there is a presumption against granting or restoring a security clearance. *See Department of Navy v. Egan*, 484 U.S. 518, 531 (1988) ("clearly consistent with the national interest" standard for the granting of security clearances indicates "that security determinations should err, if they must, on the side of denials"); *Dorfmont v. Brown*, 913 F.2d 1399, 1403 (9th Cir. 1990), *cert. denied*, 499 U.S. 905 (1991) (strong presumption against the issuance of a security clearance). Consequently, it is necessary and appropriate to place the burden of persuasion on the individual in cases involving national security issues. In addition to his own testimony, we generally expect the individual in these cases to bring forward witness testimony and/or other evidence which, taken together, is sufficient to persuade the Hearing Officer that restoring access authorization is clearly consistent with the national interest. *Personnel Security Hearing (Case No. VSO-0002)*, 24 DOE ¶ 82,752 (1995); *Personnel Security Hearing (Case No. VSO-0038)*, 25 DOE ¶ 82,769 (1995) (individual failed to meet his burden of coming

forward with evidence to show that he was rehabilitated and reformed from alcohol dependence).

B. *Basis for the Hearing Officer's Decision*

In personnel security cases under Part 710, it is my role as the Hearing Officer to issue a decision as to whether granting an access authorization would not endanger the common defense and security and would be clearly consistent with the national interest. 10 C.F.R. § 710.27(a). Part 710 generally provides that "[t]he decision as to access authorization is a comprehensive, common-sense judgment, made after consideration of all relevant information, favorable and unfavorable, as to whether the granting or continuation of access authorization will not endanger the common defense and security and is clearly consistent with the national interest." 10 C.F.R. § 710.7(a). I must examine the evidence in light of these requirements, and assess the credibility and demeanor of the witnesses who gave testimony at the hearing.

III. *ANALYSIS*

A. *Criterion (j) Concerns*

1. *The Individual's Diagnosis of Alcohol Abuse.*

In his Report, the DOE psychiatrist found that the individual suffers from Alcohol Abuse as that condition is described in the "Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition" (DSM-IV). In making this finding, the DOE psychiatrist chiefly relied on the individual's history of alcohol consumption, as documented by military and police records, and as described by the individual in three Personnel Security Interviews (PSI's) with DOE security personnel and in his own examination of the individual. 1/ Because the individual has challenged the DOE psychiatrist's findings and diagnosis, I will describe the DOE psychiatrist's findings regarding the individual's alcohol consumption in some detail.

The DOE psychiatrist found that the individual has had a long history of problems with alcohol. In his Report, he states that

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1/ The DOE psychiatrist also administered a personality test to the individual, the Minnesota Multiphasic Personality-2 (MMPI-2), but did not rely on the results for his diagnosis.

the individual told him that he began drinking while a teenager and that while in high school he generally drank to intoxication when he did drink, which was about every two or three months. Report at 2. The DOE psychiatrist then finds that the individual's alcohol intake greatly increased when he entered the Navy in 1982, and remained high for several years:

> In his [2002 PSI], he recalled that when he was in the Navy he was "probably legally intoxicated every weekend" (Page 24).

Id. The individual's drinking resulted in a nonjudicial punishment in the Navy, known as a captain's mast, for Drunk on Duty. The individual described the circumstances as follows to the DOE psychiatrist:

> He recalled that he was 12th on the duty list and did not think he would be required to stand watch. He was out drinking that evening before a voyage . . . He returned to barracks, and at 3 AM was told he would be required to stand watch. He went to stand watch, but was found to be intoxicated.

Id. After he entered college in 1986, the individual began a pattern of heavy weekend drinking.

> He recalled that both he and his roommate drank heavily in college and stated, "oh, on a weekend we'd drink a case, a case of beer with no problem, you know." [1992 PSI at 21]. During the week he would have one or two beers each evening, and estimated that he drank to intoxication about 30 percent of the times he drank. In his 1992 PSI, he described his college pattern of heavy weekend drinking as "Binge, binge drinking, classic, uh classic start off to a problem is doing that." (Page 22).

Id. In 1988, the individual had his second alcohol related legal problem and his first DWI arrest. This arrest indicated a high level of intoxication.

> He was drinking at a friend's house and estimated that he may have had as many as 20 drinks, but could not recall the exact number. In our interview I asked him why police officers stopped him while he was driving home and he recalled that he was "going the wrong way" while

> driving. . . . His blood alcohol level was measured by Breathalyzer and found to be 0.23 grams percent.

Id. The Report notes that this level is quite high, since a blood-alcohol level (B.A.L.) Of 0.08 grams per cent is considered legally intoxicated in the state of where the individual resides, and blood levels that high or higher have been shown to cause significant impairment in skills needed to drive an automobile. The Report discusses how the B.A.L. is a function both of alcohol consumption and the individual's rate of metabolism, with long time heavy drinkers often developing the ability to metabolize alcohol faster.

> An example of an alcohol consumption pattern and resultant B.A.L. would be a person who drank 15 [alcoholic] drinks over a four hour period of time. During those four hours, four of the drinks would be metabolized, leaving 11 drinks in the person's system, yielding a B.A.L. of about 0.22. This was approximately the B.A.L. of [the individual] when he was arrested for his 1988 DWI.

Id. at 3.

The individual reported that he did not drink for two years after the DWI as required by his probation. In about 1991, the individual resumed drinking. In his Report, the DOE psychiatrist refers to statements made by the individual concerning his level of alcohol consumption from 1991 until 2002.

> Over the coming years he commonly drank three or four times a week, consuming two or three beers per time. On weekends he might drink four or five drinks per occasion. He estimated he might become intoxicated once or twice a month. He denied any history of alcoholic blackouts. His first DOE PSI regarding alcohol issues was [in 1992].
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> In 1996 DOE held a second PSI and discussed alcohol related issues. [The individual] estimated his alcohol consumption at a couple of drinks a day during the week, and probably four or five drinks on Saturday or Sunday. He recalled that he would drink to the point of intoxication, "maybe twice a month." [1996 PSI at 47] [In his 2002 PSI, he] acknowledged, "You know, I, I've probably driven in the past 14 years legally intoxicated". [2002 PSI at 40].

Id. at 3. In early February 2002, the individual had his third alcohol related legal problem and his second DWI. The incident occurred while he was on a business trip. The circumstances surrounding his arrest are described in the Report as follows:

> In the early evening he had drinks at the hotel bar. He estimated he had about five drinks there, consuming bourbon in Coca-Cola. His coworker recalled him drinking heavily at the happy hour. [The individual] then went to dinner alone at about 8 PM and purchased a fifth (750 cc) of bourbon and a sixpack of Coca-Cola. He drank the whiskey mixed with the Coca Cola while he was driving in his car. At 12:06 AM he was stopped by [the] police after driving southbound in the northbound lane of the road. The arresting officer found an Evan Williams whiskey bottle in the vehicle, opened and two-thirds empty. Five of the six Coca-Cola's had been consumed. [The individual] failed a field sobriety test that was given. A blood-alcohol level was determined by Breathalyzer to be 0.177.

Id. at 4. The DOE psychiatrist then noted that a blood alcohol level of 0.177 is consistent with consuming about 15 drinks over a six hour period of time. *Id.* Following this incident, at his 2002 PSI, the individual described his drinking pattern to DOE officials. The DOE psychiatrist cites the following statements from that interview as indicating that the individual realized that he had a binge drinking problem and occasionally couldn't seem to identify the point of excessive drinking after he started drinking.

> In that interview, he also noted "I certainly don't seem to have the capability to tell when I've had, you know, near too much. It seems to be a fairly large depth function there from just had a few to too many." [2002 PSI at 53] He noted a similar problem in that interview when he stated, "but certainly there is a trip point where past I should not drink." "And since I can't seem to identify that after I've been drinking, [I've] pretty much made the decision that I'll just stop completely." [2002 PSI at 32].

Id. at 5. Finally, the DOE psychiatrist stated that although at his 2002 PSI the individual had indicated an intention to stop drinking, he reported at their interview four months later that he had resumed drinking.

> He indicated that he had come to the decision that, "I can drink moderately." Regarding his alcohol use he stated, "I don't think I have a problem." He said that he recently drinks about four or five drinks a week.

Id. at 5.

After summarizing this history at page 8 of the Report, the DOE psychiatrist states "I conclude that [the individual] suffers from Alcohol Abuse." Report at 8. In addition, he writes that:

> Although I did not diagnose that [the individual] suffered from the more severe condition of Alcohol Dependence, he does meet two of the criteria for Alcohol Dependence: Alcohol is often taken in larger amounts or over a longer period than was intended (criterion #3); and , There is a persistent desire or unsuccessful efforts to cut down or control alcohol use (criterion #4). As noted above, [the individual's] primary problem with alcohol is in a "binge drinking" pattern, when he often couldn't seem to identify the point at which he should stop drinking. He has expressed a desire to stop or cut down his drinking, but currently he has resumed alcohol consumption.

Id. at 9. In his testimony at the hearing, the DOE psychiatrist reiterated these findings and conclusions contained in his Report, and further discussed the bases for his diagnosis of Alcohol Abuse and his assessment of the individual's rehabilitation efforts.

In challenging the DOE psychiatrist's diagnosis, the individual first contends that the DOE psychiatrist ignored the requirements for a diagnosis of Alcohol Abuse contained in the DSM-IV. According to the DSM-IV, substance abuse is a "maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances." DSM IV at 182. The criteria for substance abuse are set forth in the DSM IV. Those factors include:

> (1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home . . .;
>
> (2) recurrent substance uses in situations in which it is physically hazardous (e.g., arrests for substance-related disorderly conduct);

> (3) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); and
>
> (4) continued substance uses despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effect of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

DSM IV at 182. The DSM IV further specifies that one or more of these criteria must occur in within a 12-month period. Referring to the above factors, the individual contends that he should not have been diagnosed with Alcohol Abuse because there was no recurrence of his substance related legal problems during any 12 month period. In this regard, he points out that his alcohol related arrests occurred in 2002 and 1988, and he was charged with "Drunk on Duty" in 1985.

In his testimony (TR at 78-79), the DOE psychiatrist pointed out that the DSM IV specifically refers to its diagnostic criteria as guidelines to be employed by individuals with appropriate clinical training and experience, and specifically permits a diagnosis in instances where the clinical presentation "falls just short of meeting the full criteria for the diagnosis as long as the symptoms that are present are persistent and severe." 2000 DSM IV Text Revision, p. xxxii). He concluded that the pattern of binge drinking acknowledged by the individual and evidenced by the 1988 and 2002 DWI's indicated severe and persistent symptoms.

> And to address that binge drinking element more, his episodes were particularly risky. I mean, he was driving the wrong way on a road, so impaired that he couldn't even tell which side of the road to drive on.
>
> . . . So the binge drinking and a high blood level [for alcohol at the time of his arrests] -- as a clinician would make me very concerned about the severity of his alcohol abuse, that he needs to stop drinking. And he acknowledged it at different points, that he was kind of playing roulette, in a sense, that when he starts drinking, oftentimes he couldn't stop. Once you know that, and then continue to attempt to try to drink in moderation, that's a sign that the alcohol abuse is present.

TR at 83-84. He also testified that since DWI's require effective police intervention while a person is driving under the influence of alcohol, "DWI's are almost certainly the tip of an iceberg of the number of episodes that have actually occurred of the person driving while intoxicated." TR at 73. In this regard, he noted that the individual had acknowledged that he was driving drunk at other times, although "not necessarily in the recent 12 months." TR at 81.

I conclude that the DOE psychiatrist made a proper diagnosis based upon his clinical judgment. *See Personnel Security Review, Case No. VSA-0396*, 28 DOE ¶ 83,020 (2001); *Personnel Security Review, Case No. VSA-0298*, 28 DOE ¶ 83,001 (2000). As indicated by the DOE psychiatrist's testimony at the Hearing (TR at 46-47), he is a medical professional with extensive clinical experience in diagnosing and treating alcohol related illnesses. He is clearly qualified as an expert medical witness in that area. His diagnosis also appears to be reasonable and based on a thorough study of the individual's own statements concerning his alcohol use, as well as the available police records concerning the DWI's.

In an effort to challenge the DOE psychiatrist's diagnosis, the individual submitted a letter, dated June 29, 2003, from his primary care physician. She writes that the individual has been under her care for more than five years, and she does not believe that he suffers from alcohol abuse.

> I am aware of [the individual] being charged with DWI, and I am aware of past use of alcohol. In the time that I have known [the individual], I have not been concerned regarding the possibility of excessive alcohol abuse. The medical history of chronic alcohol abusers usually contains frequent treatment for burns, fractures or unusual infections. Alcohol abusers often are debilitated, and sometimes conjure up symptoms that are not supported by physical or laboratory examinations. I have reviewed [the individual's] medical history and find none of these traits. In the past, we have discussed his use of alcohol and it is my medical opinion, supported by laboratory findings that he never suffered from alcoholism or abuse.

Individual's Hearing Exhibit 1. I am not convinced by these assertions. While the presence of physical symptoms such as burns, broken limbs, or liver inflammation may be associated with "chronic alcohol abusers", the DSM IV criteria do not require them for a

diagnosis of alcohol abuse. Moreover, although she states that she is aware of the individual being charged with DWI, her letter does not indicate awareness of the extremely high blood alcohol levels at the individual's DWI's that were of particular concern to the DOE psychiatrist. Nor does she indicate that she is aware of the individual's past admissions concerning driving while intoxicated or having difficulty with occasional binge drinking. Her medical opinion concerning the individual would be much more persuasive if she had attended the Hearing and addressed these specific concerns regarding the individual's use of alcohol. Accordingly, I find that the contentions presented in her letter do not convince me that the DOE psychiatrist's diagnosis of Alcohol Abuse is erroneous. 2/

The individual also challenges the DOE psychiatrist's statement in his report that the individual's liver enzyme levels fall in a "gray area" with regard to possible alcohol abuse. As part of his evaluation of the individual in July 2002, the DOE psychiatrist tested his levels of Gamma Glutamyltransferase (GGT) and made the following findings in his report.

> His [GGT] liver enzyme level was within the higher ranges of normal (37; normal reference 5 -- 40). In discussing Alcohol Abuse, DSM-IV-TR comments: *"Associated Laboratory Findings: One sensitive laboratory indicator of heavy drinking is an elevation(>30 units of [GGT]. This finding may be the only laboratory abnormality. At least 70 percent of individuals with a high GGT level are persistent heavy drinkers (i.e., consuming eight or more drinks daily on a regular basis)"* (Page 218). Since [the individual's] Gamma GT level is within the normal range for the [testing laboratory's] reference, it does not provide strong evidence of excessive drinking. However, since it is in the "gray area" between 30 and 40 units, this level is still consistent with possible excessive drinking. Excessive alcohol use is the most common cause of abnormal Gamma GT elevation, and [the individual] is negative for the next most common causes; infectious

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2/ Following the Hearing, the individual submitted an August 6, 2003 memorandum from his EAP counselor, who stated that it was his "impression" that the individual is not alcohol dependent, but that "due to the DWI's, he manifests some elements of alcohol abuse." I do not find that these observations in any way conflict with the DOE psychiatrist's diagnosis.

> hepatitis, liver-damaging medications, or symptomatic acute medical illnesses.

Report at 7. The individual contended that these statements by the DOE psychiatrist infer that his GGT level of 37 reveals him to be a heavy drinker. He referred to the letter from his primary care physician indicating that she had examined his laboratory tests as far back as 1998 and found no laboratory evidence of alcohol abuse in her patient. Individual's Exhibit 3. At the Hearing, the DOE psychiatrist stated that the individual's GGT level was in the normal range and that he had regarded it as normal at the time he made his diagnosis. TR at 116, 120-121. However, he testified that a normal GGT level does not establish that the individual has no alcohol related problem.

> It's difficult to use tests to prove an absence of something, because the problems we're talking about have a pretty high threshold before they would start showing up in medical labs. You'd have to drink a lot before your lab results start to become abnormal.

TR at 120. He stated that occasional binge drinking would have less of an impact on the GGT level than chronic heavy drinking. *Id.*

Accordingly, I conclude that the DOE psychiatrist relied on the individual's history of alcohol use rather than on his GGT level when he made his diagnosis of Alcohol Abuse, and that the diagnosis was consistent with the individual's normal GGT level.

The individual also took issue with the Report's finding that his "family history is positive for alcohol abuse in his father." He said he told the DOE only that he had heard from his mother that his father had "some sort of problem while he was in the army" but that he had stopped drinking completely by the time his oldest sibling was born. TR at 97. On hearing this, the DOE psychiatrist indicated that "it could be that you do not have a family history positive for alcohol abuse." TR at 98. However, the DOE psychiatrist also indicated that this lack of family history would not alter his diagnosis and testified that "most people with alcohol abuse or dependence do not have a positive family history of alcoholism." TR at 139.

Finally, the individual contended that the DOE psychiatrist should not have relied for his diagnosis on the individual's statements to him and to PSI interviewers concerning his drinking to intoxication and driving while intoxicated. He argued that "intoxication" is

too vague and general a term to be meaningful. TR at 99-100. I agree with the DOE psychiatrist that there is a generally accepted definition people have of intoxication, and that it was proper to rely on that general understanding of the term in interpreting the individual's statements. TR at 100-101. The individual also argued that his statement that he had "probably driven in the past 14 years legally intoxicated" [2002 PSI at 40] may not necessarily be true.

> I've used a blood alcohol calculator on-line and looked at what my frequency or what my drinking habits were and time frame and the amount that I've drank, and I actually think that I was rarely legally intoxicated.

TR at 129. I am not convinced by this assertion. I cannot accept the individual's unsupported statement that he now believes that he was "rarely legally intoxicated" during the period between his 1988 and 2002 DWI's. In challenging the accuracy of an admission that he made during a PSI that raised a concern with the DOE, the individual has the burden of providing evidence to support his revised position. In my May 8, 2003 letter to the parties, I advised the individual that corroborative testimony would be crucial to enabling him to mitigate the concerns raised by the Notification Letter. I strongly urged him to present the testimony of relatives, close friends, or other individuals who are knowledgeable concerning these issues. The individual has presented no corroborative testimony concerning his drinking habits during this period, so his revised assertion must be rejected.

Based on the DOE psychiatrist's Report and his testimony, I find that the individual was properly diagnosed as suffering from Alcohol Abuse. The issue in this case is whether the individual has mitigated the concerns arising from this diagnosis by demonstrating rehabilitation or reformation. Accordingly, I will proceed to consider the recommendations for treatment, and the individual's response to those recommendations.

> 2. *The Individual's Efforts Towards Rehabilitation or Reformation.*

Having found no rehabilitation or reformation from alcohol abuse, the DOE psychiatrist made the following recommendations concerning treatment that would result in rehabilitation.

> First of all, [the individual] would need to have some desire to enter into treatment. If he chose to go into

> treatment, outpatient treatment of moderate intensity would be adequate. By moderate intensity I mean a treatment regimen such as Alcoholics Anonymous a few times per week, perhaps with individual counseling as well, and should include maintenance of sobriety. Duration of such treatment should be a year or two to provide adequate evidence of rehabilitation and reformation.

Report at 10.

Clearly, a commitment to abstain from alcohol and to seek proper treatment are necessary requirements for any showing of rehabilitation by the individual from his diagnosis of Alcohol Abuse. In his October 29, 2002 response to the Notification Letter, the individual stated that he has abstained from alcohol since August 11, 2002 and plans to continue his sobriety indefinitely. He also stated in that letter that he has met with an Employee Assistance Program (EAP) counselor and with a clinical substance abuse counselor through his medical plan, and "will abide by whatever treatment the above two counselors recommend." October 29, 2002 response at 3. At the hearing, the individual stated that he had entered a testing program through the EAP in November 2002, and has been tested for alcohol on a monthly basis since then. He submitted an EAP prepared summary of these tests indicating that they had all been negative for the presence of alcohol. Individual's Hearing Exhibits 5 and 6. He stated that although he had stopped drinking in August 2002, he did not claim to have a documented period of sobriety prior to beginning this testing on November 11, 2002. TR at 161.

I have reviewed the test results submitted by the individual and find that they are not adequate to document his sobriety from November 11, 2002 through the date of the Hearing. The tests were conducted randomly on a monthly basis during the work day. The DOE psychiatrist testified that this limits the time frame for detection.

> Basically, you have to have used alcohol a few hours before to get caught on a urine or breathalyzer. So if it's done in the workplace, it would basically only detect alcohol ingestion from that morning until the test was drawn.

TR at 187. Accordingly, the individual could have consumed substantial amounts of alcohol in the evenings and on weekends

without risking discovery through this workplace testing program. In addition, the fact that the individual rejected my specific advice to present the testimony of his wife and friends to corroborate his sobriety raises the concern that their testimony would not have been supportive of his claim.

At the Hearing, the individual also stated that he was meeting regularly with his EAP counselor. TR at 164. In his August 6, 2003 memorandum, the EAP counselor did not state whether he was meeting with the individual on a regular basis. However, he did state that the individual had entered into a recovery agreement with the EAP that included the monthly random testing and required Alcoholics Anonymous (AA) meetings. In his testimony at the Hearing, the individual stated that he had not been involved with AA meetings since 1989.

> I talked with [the EAP counselor] about this, and he pretty much understood what I was saying about . . . whether or not . . . I actually was diagnosed with alcohol abuse, and [he] thought that as long as I was remaining abstinent that there wasn't a problem in his mind that I postpone the treatment start, if we thought we needed it, until after the hearing and the results of the hearing.

TR at 166-67. After hearing the individual's testimony, concerning his rehabilitation efforts, the DOE psychiatrist stated that he had not changed his opinion that there was inadequate evidence of rehabilitation or reformation.

> It was a little disconcerting actually to hear that there is really -- it sounded to me . . . like there is no program in place yet, almost awaiting the results of this hearing before a definitive program would be set up.
> It seems to me that he doesn't . . . think there is a problem. The only problem would be not the drinking, but the loss of a clearance, and if he didn't lose the clearance, there was no problem.

TR at 188.

In the administrative review process, the Hearing Officer has the responsibility for making the determination as to whether an individual with alcohol and/or drug problems has brought forward information which demonstrates rehabilitation or reformation. *See* 10 C.F.R. § 710.27. In the present case, I am unable to find that

the individual has demonstrated sufficient evidence of rehabilitation or reformation from his diagnosis of alcohol abuse at this time to mitigate the DOE's concerns regarding that diagnosis. My position is based primarily on the individual's failure to document his claimed period of abstinence and on the expert testimony by the DOE's board-certified psychiatrist that the does not appear to understand that he has a problem with alcohol and does not appear to have really begun a recovery program. My observations at the Hearing also lead me to agree with the DOE psychiatrist's assessment that the individual has not yet recognized that he has a problem with alcohol. With no recognition of his problem, no effective rehabilitation program, and no period of demonstrated abstinence, the individual's risk of relapse remains significant. Accordingly, I believe that it would not be appropriate to restore the individual's access authorization at this time.

B. *Criterion (l) Concerns*

With respect to Criterion (l), the Notification Letter finds that information in its possession indicates that the individual has engaged in unusual conduct or is subject to circumstances which tend to show that he is not honest, reliable, or trustworthy; or which furnishes reason to believe that he may be subject to pressure, coercion, exploitation, or duress which may cause him to act contrary to the best interests of the national security. In this regard, the Notification Letter refers to the individual's alcohol related arrests in February 2002 and December 1988, his being charged with "Drunk on Duty" in December 1985 while serving in the Navy, and his admission that in the past 14 years he has driven while legally intoxicated.

The cited arrests and other actions of the individual resulted from his use of alcohol, and are not the type of unusual behavior that is properly raised as an independent security concern. As discussed above, the individual has not demonstrated rehabilitation from his diagnosis of alcohol abuse. I therefore find that the Notification Letter's Criterion (l) concerns are part of the Criterion (j) concern of alcohol abuse which the individual has not yet mitigated. If we were to resolve the Criterion (j) security concern in the individual's favor, it would be appropriate to reinstate the individual's access authorization.

IV. *CONCLUSION*

For the reasons set forth above, I find that the individual suffers from alcohol abuse subject to Criterion (j). Further, I find that this derogatory information under Criterion (j) has not been mitigated by sufficient evidence of rehabilitation or reformation. Accordingly, after considering all the relevant information, favorable or unfavorable, in a comprehensive and common-sense manner, I conclude that the individual has not yet demonstrated that restoring his access authorization would not endanger the common defense and would be clearly consistent with the national interest. It therefore is my conclusion that the individual's access authorization should not be restored. The individual may seek review of this Decision by an Appeal Panel under the regulation set forth at 10 C.F.R. § 710.28.

Kent S. Woods
Hearing Officer
Office of Hearings and Appeals

Date: October 14, 2003